The Sun Home Health

We Believe in Excellence! - Since 1997

AIDE CARE PLAN

Patients Name:		DOB:
Street Address:		Phone #:
City:	State:	Zip:
Emergency Contact/Relationship		Phone #:

Days Needed: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Times Needed:

Client Dx/Problem

PRECAUTIONARY AND OTHER PERTINENT INFORMATION - Check all that apply

- ☐ Lives alone
- ☐ Lives with other
- ☐ Alone during the day
- ☐ Bed bound
- ☐ Bed rest/BRPs
  - ☐ Up as tolerated
- ☐ Amputee (specify): _____
- ☐ Partial weight bearing
  - ☐ R ☐ L
- ☐ Non - weight bearing:
  - ☐ R ☐ L
- ☐ Fall precautions
- ☐ Speech/Communication deficit
- ☐ Vision deficit: ☐ Glasses
  - ☐ Contacts
  - ☐ Other: _____
- ☐ Hearing deficit:
  - ☐ Hearing Aid
- ☐ Dentures: ☐ Upper ☐ Lower √ Partial
- ☐ Forgetful/Confused
- ☐ Urinary catheter
- ☐ Prosthesis (specify): _____
- ☐ Allergies (specify): _____
- ☐ Diabetic ☐ Do not cut nails
  - ☐ Diet:
- ☐ Seizure precaution
- ☐ Prone to fractures
- ☐ Other (specify): _____

	Assignment	Every Visit	Wk	Other Comments/Instructions
Bath	Tub/Shower	☐	☐	
	Bed Bath Partial/Complete	☐	☐	
	Assist Bath Chair	☐	☐	
Personal Care	Personal Care	☐	☐	
	Assist w/ dressing	☐	☐	
	Groom Hair	☐	☐	
	Shampoo	☐	☐	
	Skin Care	☐	☐	
	Teeth Care	☐	☐	
	Other (specify):	☐	☐	
Procedures	Toileting Assist	☐	☐	
	Catheter Care	☐	☐	
	Ostomy Care	☐	☐	
	Medication Reminder	☐	☐	
	Other (specify):	☐	☐	

	Assignment	Every Visit	Wk	Other Comments/Instructions
Activity	Assist w/ Ambulation W/C / Walker / Cane	☐	☐	
	Mobility Assist Chair/Bed Shower/Tub	☐	☐	
	Exercise Per PT/OT Care Plan	☐	☐	
	Other (specify):	☐	☐	
Nutrition	Meal Preparation	☐	☐	
	Assist with Feeding	☐	☐	
	Limit/Encourage Fluids	☐	☐	
	Grocery Shopping	☐	☐	
	Other (specify):	☐	☐	
Other	Laundry	☐	☐	
	Light Housekeeping Bedroom/Bathroom/ Kitchen/Bed Linen	☐	☐	
	Equipment Care	☐	☐	
	Transportation	☐	☐	